

**PARTICIPANT DIRECTED SERVICES
RIGHTS, RESPONSIBILITIES AND RISKS STATEMENTS**

I understand that I have the **RIGHT** to:

- Choose whether an authorized service will be provided by a traditional waiver provider or through Participant Directed Services;
- Work with my case manager in developing my plan of care;
- Have a monthly face-to-face visit with my case manager; and
- Contact my case manager twenty-four (24) hours per day and seven (7) days per week if a question arises.

I understand that I have the **RESPONSIBILITY** to:

- Be trained to coordinate my care prior to beginning Participant Directed Services services;
- Participate in monthly face-to-face visits with my case manager;
- Work with my case manager to determine my natural supports (family and friends) who can assist me when my Participant Directed Services are not being provided;
- Hire and train employees who I trust to perform the services outlined on my plan of care;
- Work with my case manager to ensure my employees have completed pre-employment checks;
- Keep up with my employees' time and the services provided, and ensure timesheets and service notes are documented correctly before being submitted to my case manager; and
- Pay my monthly patient liability on time, if applicable while maintaining my Medicaid eligibility.

I understand that I have the **RISK** of being terminated from Participant Directed Services:

- If I fail to pay my monthly patient liability;
- If I do not use my Participant Directed Services within sixty (60) consecutive days;
- If I do not make appropriate decisions concerning my Participant Directed Services and place my health, safety and welfare in jeopardy; and
- If I am non-compliant with my plan of care;

Member Name:_____

Medicaid ID:_____

I appoint_____ as my representative to manage my services for the Participant Directed Services Waiver.

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

As the participant or designated representative choosing Participant Directed Services, I have read the above Rights, Responsibilities and Risks statements. I have had all my questions answered by my case manager, and I have received a copy of these statements from my case manager. I understand that I must be at least 21 years of age, must not be paid for the role of representative, be responsible in managing care for the participant and participate in training as directed by the case manager. I further understand that if I submit any false information to the SCL waiver provider and Department that I am subject to criminal prosecution, jeopardize my Participant Directed Services eligibility, and will be required to return any benefits received.

Participant/Representative Signature

Relationship to Participant

Date

Case Manger Signature

Date